Social prescribing in general practice

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We know that health and wellbeing is about much more than medicine. Issues such as loneliness, poverty, physical inactivity and stress underpin many of the problems our patients are experiencing, and no drug or clinical intervention holds the answer. This understanding is reflected in modern medical theory and education through the replacement of the traditional biomedical model of disease with the biopsychosocial model. As the workload of the NHS shifts towards an increase in long-term conditions, which now account for 70% of the total budget spend (NHS England, 2014a), multi-morbidity, mental health problems, obesity and lifestyle-related diseases; the importance of addressing the psychological and social determinants of health is clearer than ever.

GPs face these challenges on the front line and aim to provide holistic care, yet often feel ill-equipped to do so (Smith, O'Kelly, & O'Dowd, 2010). Attempting to address complex psycho-social issues within the context of the 10-minute consultation, already crowded with other agendas such as the Quality Outcomes Framework, is at best challenging. At worst, it can feel like opening a can of worms to which no solutions can be offered. Adopting a medical model to address symptoms is often quicker, easier and perhaps perceived as a less risky option. It is what many doctors were trained to do, and what patients have learned to expect. All too often this approach results in an unnecessary prescription, investigation or referral. In addition to being ineffective, this approach brings the increased risk of harm to the patient through side effects, complications and polypharmacy. In the long term, it can also fuel a disempowering cycle of further medicalisation of symptoms and looking to the healthcare system for solutions (doctor dependency), rather than promoting self-efficacy and addressing real-world root causes.

In recent years there has been a broader recognition at strategic level that the traditional 'diagnose–treat–cure' model is outdated and insufficient to address current and future demands on the health service. The NHS Five Year Forward View (NHS England, 2014b) proposes shifting towards a model focusing on much wider individual and community engagement through three core components:

- Getting serious about prevention
- Empowering patients and
- Engaging communities

Progress has already been made in addressing psychological needs in the community through initiatives such as Improving Access to Psychological Therapies, which makes it quicker and easier for patients to access talking therapies and psychological interventions such as cognitive behavioural therapy. Going forward, a key part of the strategy for addressing patients presenting with issues related to unmet social needs is likely to be the concept of social prescribing.

What is social prescribing?

Social prescribing is an umbrella term for a host of strategies that provide a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a range of non-clinical services, often provided by the voluntary or community sector. A social prescribing scheme can also help to identify demand and promote the development of appropriate local services. Broadly, these services tend to fall into the following categories:

- Arts and cultural activities
- Physical activity
- Healthy eating, cookery, food preparation
- Befriending
- Learning, educational and volunteering opportunities
- Financial advice and benefits support
- One-to-one coaching and support

How does it work?

There are various models of social prescribing. At a basic level, it may consist in providing information about local services (e.g. display boards/leaflets) with the onus being on the patient to make contact. GPs themselves may recommend particular services, with which that they are familiar and feel will be of value to the patient. In some cases this is accompanied by a social 'prescription' for the intervention, which can lend weight and formality to the recommendation. Increasingly, however, practices are making use of dedicated intermediaries known as facilitators or community navigators. These are usually

experienced volunteers with a background in the health, social or voluntary sector. They may work for a single practice (usually part-time) or as part of a regional social prescribing hub/referral centre. Under this arrangement, the GP triages patients, identifying those who would benefit from the social support offered by the community navigator. The navigator is able to spend more time with individuals to help identify specific patient needs: for example, arranging a volunteer to accompany a socially isolated person on their first attendance at a group meetup (which might otherwise feel intimidating). See Box 1 for examples of UK social prescribing schemes.

Box 1 Examples of social prescribing schemes.

- The Bromley by Bow Centre: www.bbbc.org.uk
- Rotherham Social Prescribing Service: www.varotherham.org.uk/social-prescribing-service
- Age UK Yorkshire & Humber social prescribing pilot project: www.ageconcernyorkshireandhumber.org.uk/uploads/files/Social%20Prescribing%20Report%20new.pdf
- Brighton & Hove social prescribing pilot project: www.bh-impetus.org/wp-content/uploads/2015/12/CN-Full-Evaluation-Nov-2015.pdf

Proponents of social prescribing argue that the potential benefits are substantial and wide-reaching. Service users benefit from a more holistic approach, aimed at tackling the root cause of their problems. This can lead to more self-directed and sustainable solutions, as well as to fewer unnecessary medical interventions. The health service can benefit from a more efficient use of resources, resulting in cost-saving and freeing of clinicians' time. There can also be many more subtle benefits that are felt in the wider community through having a larger voluntary sector engaged in supporting those in need.

Despite such benefits important questions remain. For some GPs, the concept of social prescribing may sit uncomfortably with their own health beliefs and views on the role and responsibilities of a doctor. Others may fear additional workload at a time when many GPs already feel overstretched. Similarly, those in the voluntary sector may worry about the capacity to cope if there were an expansion in referrals and whether appropriate funding and resources would follow. For patients, there is a risk that some will feel 'fobbed off' by their doctor. There is also a risk that an expansion in social prescribing would increase the risk of important medical symptoms being overlooked, leading to diagnostic delay. Ultimately, however, the biggest challenge is likely to be the issue of funding, and whether, or to what extent, it is the responsibility of the health service to address society's non-medical problems.

In the short term, setting up a social prescribing scheme will constitute an extra cost to clinical commissioning groups/practices above that of routine care. To justify this, schemes will need to demonstrate tangible benefits, i.e. cost savings. To date much of the evidence gathered in this area has been for individual initiatives (e.g. referrals to an exercise prescription programme) as opposed to social prescribing schemes as a whole. A recent review of social prescribing studies (Kilgarriff-Foster & O'Cathain, 2015) found that stakeholders viewed social prescribing as acceptable and feasible, and perceived it as improving patient wellbeing and reducing use of health services; however, the report concluded that there was a dearth of high-quality evidence of effectiveness and long-term cost-effectiveness.

Demonstrating the effectiveness of 'softer' interventions, such as social prescribing, is notoriously difficult. Many studies fall foul of the traditional hierarchy of evidence, which is better suited to measuring 'hard' clinical outcomes, not least because of the fact that the principal benefits may be long-term, diffuse and perhaps not even patient-specific. The fact that robust data collection may not be routine in the third sector poses an additional challenge. However, in the wake of the NHS 5-year forward view there is already significant work being done to bolster the evidence base for non-clinical and community-based interventions, incorporating broader measures of value such as wellbeing, NHS sustainability and social return on investment (NHS England, 2014c).

As with any intervention, social prescribing will not work for everyone, and will not provide a panacea for society's ills, but if we are to overcome the challenges facing the health service in the 21st century we need to accept that the divide between medical and social problems is almost always an artificial one, and that any meaningful solutions will need to span both domains. Perhaps the greatest strength of general practice is its capacity to bridge that divide, and we should embrace social prescribing as a means to offer more truly holistic solutions to our patients.

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